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ABSTRACT

This paper concerns the high incidence of eating disorders, anorexia nervosa and bulimia, among the female population in colleges. It identifies several major issues in attempting to provide counseling services for eating disordered students (limited resources, a large estimated patient pool, length of treatment involved, and policy changes to accommodate treatment of parents) that would make such a program unfeasible under existing constraints. A new means of addressing the issue is presented, in which: (1) interdepartmental cooperation is central to the development and execution of the program on a commuter campus; (2) human development theory provides the rationale for the systemic intervention used; and (3) parents are involved in the treatment process. Recent literature in the field prompted the development of the more definitive assessment procedures and specific individualized treatment plans which are described in this paper, with guidelines provided for determining when and under what conditions parents are to be involved. (Author/NB)

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Mom and Dad return to a Commuter Campus:

A Program for Re-parenting of Eating Disordered Females

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Running head: RE-PARENTING OF EATING DISORDERED STUDENTS

Abstract

The high incidence of eating disorders, anorexia nervosa and bulimina, among the female population in colleges, has been clearly documented. This paper discusses one means of addressing this issue in which (1) interdepartmental cooperation is central to the development and execution of the program on a commuter campus,(2) human development theory provides the rationale for the systemic intervention utilized, and, (3) parents are involved in the treatment process. In addition, recent literature in the field prompted the authors to develop more definitive assessment procedures and specific individualized treatment plans which are described, with guidelines provided for determining when and under what conditions parents are to be involved.

Mom and Dad Return to a Commuter Campus:

A Program for Re-parenting of Eating Disordered Females

Introduction

In the past decade the incidence of eating problems among college age students has ranged from 13% to 67% of the non-clinical population (Halmi, Folk & Swartz, 1981; Hawkins & Clement, 1980; Olmsted & Garner, 1982). Thus it is clear that a problem of such proportion on a university campus would require a major psychological intervention effort that could not easily be met given limited resources.

In preliminary discussions on our campus an estimated incidence rate of 30% was used in an attempt to determine the amount of resources necessary to meet the needs of this population. Given our student body of over 15,000 students, it was likely that 2,250 would be female and would fall within one of the eating disorder sub-groups. (Note. The authors were aware that eating disorders appear within the male population as well, but we chose to limit our discussion to the treatment of females as they constituted the majority of cases.) With its existing staff of 2.63 FTE, the Student Counseling Program staff had the capacity to provide 420-480 individual therapy sessions per quarter which would serve less than 4% of the estimated student pool of eating disordered persons, even if all the available resources were to be devoted to that population while ignoring all of the other students typically seen in the Counseling Center. Clearly, this was not a viable option.

The problem was complicated further by the length of treatment required for eating disordered patients, i.e., one to two years. The Student Counseling Program (SCP) had been defined historically as a "short term" agency and although treatment length was unspecified, previous data indicated a range of 6-10 sessions per student was the norm. Thus, length of treatment was identified as a second major obstacle.

The third major issue in assessing this problem was treatment modality. Beginning with the work of Minuchin, Rosman & Baker, (1978), it was recognized that eating disorders are a systemic problem and family therapy is the treatment of choice. In recent times, college counseling centers have perceived the student body as independent adults and have provided services without involving the parents, as is the case in our University. To alter this policy in order to accommodate treatment of families would have further depleted the scant resources that existed. This restriction provided an additional reason for not attempting to provide specialized services for a significant portion of the student population.

Upon consideration of the major issues in attempting to provide counseling services for eating disordered students, i.e., limited resources, a large estimated patient pool, length of treatment involved, and policy changes to accommodate treatment of the parents, it was decided that such a program would not be feasible under the

existing constraints. Pursuing a different approach to the problem was clearly indicated.

Interdepartmental Cooperation

A potential solution to the problem was developed as a consequence of dialogue that subsequently took place between the SCP and the School of Professional Psychology (SOPP) which had been established four years earlier. On its faculty was a psychologist who had an interest in eating disorders and had the requisite education and training. The School had the expectation that its faculty engage in clinical practice and the faculty had formed a group practice in order to maintain clinical skills, be current "in the field," present a role model for its students to emulate, and to provide training opportunities for its students. All of these components were to be valuable ingredients in the program for the treatment of eating disordered students that was subsequently developed.

At the time that the eating disorder program was inaugurated approximately 10% of the student body had Student Health Insurance which contained a provision for psychological services. Of the remaining 90% many were likely to be covered under their parents' policies.

In order to access the necessary resources to carry out a new treatment program, the SCP made referrals to the clinical practice of the SOPP faculty wherein expertise was available for the treatment

of eating disorders. Parenthetically, it should be stated that students were provided with information about other programs in this area to maximize their freedom of choice. In referring eating disordered students in this manner, the financial arrangements were negotiated between the patient(s) and the service provider(s) and, as in any practice, a usual and customary fee was in existence along with the professional options for providing services on a reduced fee or indigent basis. Further, this procedure was consistent with established policies of the SCP, i.e., referring students who required special services in areas in which the staff did not possess the appropriate expertise. Neuropsychological assessments, and evaluations for psychotropic medication, were two examples that served as precedents.

When the program was inaugurated there were limited treatment facilities in the community for eating disorders, an in-patient unit of one local hospital and a restricted number of psychologists who listed this specialty as one, among many, of the services they provided. Our program became the only programmatic out-patient treatment center in the area. Thus, as a consequence of interdepartmental dialogue we were able to develop a program to address the needs of the eating disordered university students and the broader community as well. In so doing, we were also able to serve the educational mission of the School of Professional Psychology by including advanced graduate students and interns as extenders in the treatment program. Their stipends were supported by fees generated by the program.

The Program

Staff. Its members included two psychologists, a post-doctoral trainee, an intern (psychology), a third-year doctoral trainee in psychology, a consulting psychiatrist and consulting physicians from the School of Medicine.

Assessment. This process consisted of four elements:

1. clinical interviews of the eating disordered individual and parents
2. testing using the MMPI and Eating Disorder Inventory as the basic assessment instruments
3. food diary and eating history to establish baseline data
4. physical

Treatment Modality. The program utilized a family therapy format which had been modified to meet the specific needs of the population being served, e.g., in the treatment of bulimic patients the family sessions were increased in number and frequency in order to facilitate the development of support from the parents which had previously been lacking and which contributed to the continuation of the eating disorder. In general, the patient was seen once a week, separately from the parents who were also seen on a weekly basis. Family sessions occurred on a monthly basis although modification of frequency was altered depending upon the needs being addressed in the family.

Treatment Plans. The authors were in agreement with recent research which noted significant differences between anorexic and bulimic families

(Humphrey, 1986; Sargent, Liebman & Silver, 1985; Schwartz, Barrett & Saba, 1985). Further, we recognized variations within each disorder and developed an ABC paradigm (Engebretson & Hollander, 1986), which enabled us to more clearly identify, and ameliorate, problem areas within the subgroups. Beginning with the assessment process, we attempted to specify problems in terms of affect (A), behavior (B), and cognitions, (C), (Engebretson & Hollander, 1987) which promoted and maintained the eating disorder. This ABC paradigm formed the basis for the subsequent development of specific treatment plans.

The following are illustrations of representative ABCs:

affect - a mother of a bulimic daughter may need assistance in processing her guilt for having "failed as a mother." Her guilt interferred with her capacity to provide appropriate support for her daughter.

behavior - a father may have interrupted his anorexic daughter's individuation by writing her school assignments for her. A change in his behavior is clearly indicated.

cognitions - both parents of an eating disordered child may think she is a victim of an ailment for which neither she nor the family have resources to combat.

The ABCs for each member of the family in treatment were specified

and became the focus of the subsequent sessions in individual, couple and family modalities. Amelioration of the primary ABCs was the signal for the termination of therapy.

The following two tables are examples of treatment plans that illustrate the individualized foci in therapy.

Insert Tables I and II about here

Duration of Treatment. After the assessment process had been completed the eating disordered patient was seen for a period of 9-12 months. The parents' participation in the program was usually completed in 10-12 weeks, although additional sessions were scheduled for follow-up or when patient regression was noted.

Parents - Guidelines for involvement

In considering the participation of parents in the therapeutic process, the physical availability of the parents is of primary concern. Parents who live beyond a sixty mile radius from the treatment center are unlikely to attend regularly scheduled therapy sessions. Depending on distance from the treatment site occasional sessions may be planned or interventions via phone calls may be negotiated. Some form of family participation in the therapeutic process is encouraged whenever possible and is preferred to none at all. However, when therapy must proceed without the family being directly involved clients can be

requested to describe, identify, and process family interactions that may be contributing to their level of emotional distress and consequent eating disorder.

Various methods of coping with dysfunctional family interactions can be presented to the client who is encouraged to practice new behaviors when in contact with family members during vacations, visits, phone calls, etc. The therapist should reinforce and support the client's attempts at taking control of such responses to the family and realistically suggest that mom and dad may or may not be able to change without professional intervention. Successful therapy in this case will depend on the client's ability to modify affect, behavior, and cognitions without the expectation that the parents will necessarily undergo any corresponding change. Clients need to be assured that they can become "well" again even if the family system remains the same. Strategies to deal with parental sabotage of therapy need to be considered and explored while the client is supported in gaining separation from greater enmeshment in family issues. Feelings of guilt and anxiety frequently arise in this process and it is helpful for the therapist to predict their occurrences in the therapeutic process.

When parents are logistically available to participate in therapy, their participation can be made a condition for receiving services. The interactional patterns of the parents and eating disorder client need to be assessed as recent research suggests that family interaction

patterns of anorexic and bulimic clients differ in significant ways, and must thus be identified by the therapist in order to establish appropriate treatment goals (Humphrey, (1986); Sargent, Liebman, & Silver, (1985); and Schwartz, Barrett, & Saba, (1985).

Preliminary findings suggest that the anorexic family is over-involved with their child. This involvement tends to encourage the anoroxic to feel and act dependent on both mother and father. In addition, disagreement and conflict are denied and not processed within the family appropriately. In contrast, bulimic families tend to fluctuate between over-involvement and abandonment of the identified client. Although bulimic clients may act independently from their parents, they are usually emotionally dependent on them and make frequent contact while inviting parental involvement in their life. When parental efforts fail to help the bulimic client, parents frequently feel ineffective, become angry with the client, and ultimately abandon the client for a time. This cycle is often repeated. Feelings of anger and hostility are usually overt in the bulimic family, but these families seldom possess the skills necessary to resolve conflict effectively.

For both the anorexic and bulimic families, the therapist needs to help the parents and child develop appropriate methods of lending support to one another while simultaneously recognizing and establishing adaptive boundaries between parent and child. Additional goals may

include the identification of areas of conflict within the family and the acquisition of skills that will facilitate the resolution of such conflict and acceptance of differences. The chronological age and developmental level of the anorexic and bulimic client must also be considered in the family therapy process. In general, the younger the client is, both chronologically and developmentally, the more parental responsibility and control is involved in the therapeutic process, especially at the outset. The older, more emotionally mature clients generally require parental involvement which is more supportive and flexible in nature. Psychological problems that reside with the parents, as evidenced by the manner in which they interact with their child, can be addressed in the treatment plan; whereas marital problems between the mother and father can not be made part of that process. When these additional issues are deemed to be severe enough to disrupt treatment for the eating disordered patient, it is suggested that either individual and/or marriage therapy be recommended as appropriate.

In considering family therapy for eating disordered clients, it becomes obvious that differences exist between anorexic and bulimic families. Furthermore, the chronological age and developmental status of the identified client within these families contribute greatly to the differences between these two subgroups of eating disorders. Individualized assessment and treatment planning is deemed essential for each family unit. It is suggested that the ABC paradigm, as

described in the preceding tables, is a useful tool for assessing and treating each family's uniqueness.

Summary

The rise of eating disorders within the college age population has shown a dramatic increase in the past decade and university counseling centers traditionally have operated with resources which have been inadequate to meet existing needs and are, therefore, ill prepared to accommodate increased demands for specialized services. It is in this context that the authors of this paper worked cooperatively, across departmental lines to structure a program wherein additional financial resources could be accessed, through third party payers, to provide for the professional services for treatment of eating disordered students.

While the identified patients were of majority age, typically, parents were also involved in treatment to assist in the individuation process that had not been completed in the dysfunctional family. Recent literature had indicated that differences exist within the subgroups of eating disorders and, in extending these findings, the authors developed procedures for individualizing assessment and treatment. By bringing the parents to the campus we were able to treat all significant contributors to the systemic problem.

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TABLE 2

ABCs for mother of bulimic daughter

Problem	Intervention
Affect	
1. Difficulty expressing negative feelings to daughter	1. Encourage assertive expression of negative feelings, when appropriate
2. Collusion with daughter in passively expressing anger toward husband	2. Facilitate development of generational boundaries
3. Feeling responsible for the expression of all positive affect within the family	3. Give permission to share this responsibility thereby becoming a more appropriate model for her daughter
Behavior	
1. Inability to say "No" to any care taking chores within the family	1. Encourage assertiveness in saying no to demands of family members for tasks they could accomplish on their own.
2. Lack of involvement with discipline of daughter	2. Facilitate enpowerment in discipline
Cognitions	
1. Stereotypic conception of the role of females within the family	1. Expansion and enpowering of the role of females in the family
2. To be a good wife and mother, one must obey	2. Teach assertion skills to say no to inappropriate demands of husband and daughter

Overall goal - increase appropriate support for daughter

TABLE 1

ABCs for the father of an anorexic daughter

Problem	Intervention
Affect	
1. Intellectualizes	1. (a) Affect awareness training (b) Feedback from therapist and wife
2. Embarrassed by tender feelings	2. (a) Normalize (b) Encourage disclosure, desensitize
Behavior	
1. Inconsistent parenting	1. (a) Realign coalition between mother and daughter to father and mother (b) Teach negotiation strategies (c) Instruct in Behavioral Contracting
2. Frequently usurps her responsibility, e.g., wrote her term paper, gave free rein of charge card	2. Reframe as hurting, not helping, his daughter
Cognition	
1. Daughter had no control of her anorexia	1. Reframe as rebellion
2. Family roles and interactions are not involved in the eating disorder	2. Reality testing, i.e., noting family involvement in the eating disorder
3. It's wrong to express negative feelings toward one's child	3. Normalize
4. Love is permissive and protective for a child in every way possible	4. Reframe as promoting helplessness, dependency and illness

Overall goal - Help daughter individuate